IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

April 4, 2011

Heather Davis, Administrator
Home Again
2311 Aruba Drive
Nampa, Idaho 83686

RE: Home Again ICF, Provider #13G078

Dear Ms. Davis:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Home Again Icf, on March 28, 2011.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance

within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **April 18, 2011**, and keep a copy for your records.

Thank you for the courtesies extended to me during my visit. If you have any questions, please call our office at (208) 334-6626.

Sincerely,

TAYLOR BARKLEY
Health Facility Surveyor
Fire Life Safety & Construction Program

TB/lj

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G078	A. BUILDING 01 - HOME AGAIN B. WING _____	03/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME AGAIN ICF	2311 ARUBA DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, type V (000) wood frame construction with a composite pitched roof and two exits to grade. The facility is fully sprinklered with an NFPA 13R system and has a fire alarm/smoke detection system, as well as battery operated emergency lighting. The facility is currently licensed for 8 beds. The following deficiencies were cited during the annual life safety code survey conducted between March 24, 2011 and March 28, 2011. The facility was surveyed under the Life Safety Code, 2000 Edition, Chapter 32, New Residential Board & Care Occupancies, Impractical Evacuation Capability in accordance with 42 CFR 483.470. The survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000	See Plan of Corrections Attached RECEIVED APR 15 2011 FACILITY STANDARDS	
K 130	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on observation and interview it was determined that the facility failed to promote fire safety practices and to use equipment in the manner it was intended for. Failure to protect electrical equipment from external combustible fuels could provide an ignition and resulting fire. The facility had a census of eight clients on the day of the survey. Findings include:	K 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admin | (X6) DATE: 4/13/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 130	Continued From page 1 During a tour of the facility on March 24, 2011 at 10:10 AM observation of room #1 revealed two wickless candles laying on their sides on top of the packaged terminal air conditioner venting louvers. Wax drippings that had hardened were observed down inside the heating coil area of the unit. When questioned by the Surveyor about the candles the House Manager stated that the hot wax emitted a soothing smell that helped clients with controlling their behaviors. Actual NFPA101® Life Safety Code® 2000 Edition reference: 32.2.5.1 Utilities. Utilities shall comply with Section 9.1. 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code 110.3 Examination, Identification, Installation, and Use of Equipment. (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.	K 130		
K0017	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The separation walls of sleeping rooms are capable of resisting fire for not less than ½ hour, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15 minute thermal barrier. Sleeping room doors are substantial doors, such	K0017		

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K0017	Continued From page 2 as those of 1¾ inch thick, solid-bonded wood core construction or other construction of equal or greater stability and fire integrity. Any vision panels are fixed fire window assemblies in accordance with 8.2.3.2.2. or are wired glass not exceeding 1296 sq. in. each in area and installed in approved frames. 32.2.3.6.1 and 32.2.3.6.2. Exception No. 1: In prompt evacuation capability facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 32.2.3.6.4. Exception No. 2: This requirement does not apply to corridor walls that are smoke partitions in accordance with 8.2.4 and that are protected by automatic sprinklers in accordance with 32.2.3.5 on both sides of the wall and door. In such instances, there is no limitation on the type or size of glass panels. Door closing is regulated by 32.2.3.6.4. Exception No. 3: Sleeping arrangements that are not located in sleeping rooms are permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping. No louvers or operable transoms or other air passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited. This Standard is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that the interior walls and doors of sleeping rooms were capable of resisting	K0017		

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K0017	Continued From page 3 smoke and fire. These deficiencies have the potential to spread smoke and fire gasses into the common areas of the facility. The facility had a census of eight clients on the day of the survey. Findings include: 1. During a tour of the facility on March 24, 2011 between the hours of 10:00 AM and 10:30 AM observation of the doors to sleeping rooms #1 and #6 revealed that they were split in half lengthwise. Findings were observed and noted by the facility House Manager and Surveyor. 2. During a tour of the facility on March 24, 2011 at 10:13 AM observation of sleeping room #3 revealed a hole in the wall that is approximately eight inches in size. Findings were observed and noted by the facility House Manager and Surveyor. 3. During a tour of the facility on March 24, 2011 at 10:24 AM observation of the door to sleeping room #5 revealed a hole in the lower half of the door that is approximately six inches in size. Findings were observed and noted by the facility House Manager and Surveyor. 4. During a tour of the facility on March 24, 2011 at 10:40 AM observation of the door to sleeping room #8 revealed a hole in the lower half of the door that is approximately three inches in size. Findings were observed and noted by the facility House Manager and Surveyor. 5. During a tour of the facility on March 24, 2011 at 10:18 AM observation of sleeping room #4 revealed two holes in the wall that are approximately three inches in size each. Findings were observed and noted by the facility House	K0017		

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K0017	Continued From page 4 Manager and Surveyor.	K0017		
K0043	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD No door in any means of escape is locked against egress when the building is occupied. Exception: Delayed egress locks complying with 7.2.1.6.1 are permitted on exterior doors. 32.2.2.5.5, 33.2.2.5.5. This Standard is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that doors are operable and are not locked against means of escape. This deficiency has the potential to prevent people in this room from escaping in case of a fire or other emergency. The facility had a census of eight clients on the day of the survey. Findings include: During a tour of the facility on March 24, 2011 at 10:29 AM the House Manager was opening the door to room #7 from the interior when the door knob came off in her hand. The House Manager was unable to open the door without first having to replace the door knob on the opening mechanism. Findings were observed and noted by the facility House Manager and Surveyor.	K0043		
K0046	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1	K0046		

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K0046	Continued From page 5 This Standard is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that electrical wiring and equipment are in accordance with NFPA 70, National Electrical Code. The facility had a census of eight clients on the day of the survey. Findings include: 1. During a tour of the facility on March 24, 2011 at 9:41 AM, observation of the office revealed an extension cord powering office equipment. Findings were observed and noted by the facility House Manager and Surveyor. 2. During a tour of the facility on March 24, 2011 at 10:04 AM, observation of the office revealed a multiple electrical adapter powering office equipment. Findings were observed and noted by the facility House Manager and Surveyor. 3. During a tour of the facility on March 24, 2011 at 9:42 AM, observation of the office revealed that the light switch faceplate was missing. Findings were observed and noted by the facility House Manager and Surveyor. 4. During a tour of the facility on March 24, 2011 at 10:12 AM, observation of room #3 revealed that an electrical outlet faceplate was missing. Findings were observed and noted by the facility House Manager and Surveyor. 5. During a tour of the facility on March 24, 2011 at 10:19 AM, observation of room #4 revealed an electrical outlet cover that had been broken off on the lower half of the plate. Findings were observed and noted by the facility House Manager and Surveyor.	K0046		

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K0046	Continued From page 6 6. During a tour of the facility on March 24, 2011 at 10:55 AM, observation of the kitchen dining bar revealed an electrical outlet cover that had been broken off on the lower half of the plate. Findings were observed and noted by the facility House Manager and Surveyor. Actual NFPA Standard NFPA 101 - 2000 Edition Chapter 32 NEW RESIDENTIAL BOARD AND CARE OCCUPANCIES 32.2.5.1 Utilities. Utilities shall comply with Section 9.1. 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.	K0046		
K0056	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD PROMPT Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and initiates the fire alarm system in accordance with 32.2.3.4.1, 32.2.3.5.2. The adequacy of the water supply is documented to the authority having jurisdiction. Exception No. 1: In prompt evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and Two Family Dwellings and Manufactured Homes, is permitted. Facilities with more than eight residents are permitted. Facilities with more than eight residents are treated as two-family dwellings with regard to water supply. Additionally, entrance	K0056		

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K0056	Continued From page 7 foyers are sprinklered. Exception No. 2: Not applicable Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier. Exception No. 4: In prompt and slow evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to an Including Four Stories in Height, are permitted. Exception No. 5: Not applicable Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5. SLOW Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and initiates the fire alarm system in accordance with 32.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction. Exception No. 2: In slow and impractical evacuation capability facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and Two Family Dwellings and	K0056		

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K0056	Continued From page 8 Manufactured Homes, with a 30 minute water supply, is permitted. All habitable areas and closets are sprinklered. Facilities with more than eight residents are treated as two family dwellings with regard to water supply. Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier. Exception No. 4: In prompt and slow evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted. Exception No. 5: Not Applicable Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 32.2.3.5.5. MPRACTICAL Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with 32.2.3.4.1. The adequacy of the water supply isdocumented to the authority having jurisdiction. 32.2.3.5.2. Exception No. 1: Not Applicable.	K0056		

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K0056	Continued From page 9 Exception No. 2: In slow and impractical evacuation capability facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler system in One and Two Family Dwellings and Manufactured Homes, with a 30 minute water supply, is permitted. All habitable areas and closets are sprinklered. Facilities with more than eight residents are treated as two family dwellings with regard to water supply. Exception No. 3: Not Applicable. Exception No. 4: Not Applicable. Exception No. 5: In impractical evacuation capability facilities up to and including four stores in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stores in Height, are permitted. All habitable areas and closets are sprinklered. Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5. This Standard is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that the Sprinkler Heads were not blocked in accordance with NFPA 13R. The blocked sprinkler heads will not be able to disperse water spray as designed. The facility had a census of eight clients on the day of the survey. Findings include:	K0056		

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K0056	Continued From page 10 1. During a tour of the facility on March 24, 2011 at 10:03 AM, observation of the closet in the office revealed storage on the shelf that is blocking the sprinkler head. Findings were observed and noted by the facility House Manager and Surveyor. 2. During a tour of the facility on March 24, 2011 at 10:22 AM, observation of the closet in the exercise room revealed cardboard boxes on the shelf that are blocking the sprinkler head. Findings were observed and noted by the facility House Manager and Surveyor. 3. During a tour of the facility on March 24, 2011 at 10:30 AM, observation of the closet in the room #7 revealed storage on the shelf that is blocking the sprinkler head. Findings were observed and noted by the facility House Manager and Surveyor. Actual NFPA Standard NFPA 101 - 2000 Edition Section 9.7 Automatic Sprinklers and Other Extinguishing Equipment 9.7.1 Automatic Sprinklers. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Exception No. 1: NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted for use as specifically referenced in Chapters 24 through 33 of this Code. NFPA 13R Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including	K0056		

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K0056	Continued From page 11 Four Stories in Height 1999 Edition 2-5.1.7.3* Sprinklers shall be positioned so that the response time and discharge are not unduly affected by obstructions such as ceiling slope, beams, or light fixtures.	K0056		
K0147	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff no less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1 This Standard is not met as evidenced by: Based on interview it was determined that the facility failed to ensure that staff reviewed the emergency plans not less than every two months. This deficiency can result in untrained staff that may not react appropriately in an emergency. The facility had a census of eight clients on the day of the survey.	K0147		

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K0147	Continued From page 12 Findings include: During staff interview on March 24, 2011 at 9:55 AM, when questioned by the Surveyor about staff training the House Manager stated that the facility did not review emergency plans and also did not keep any training records for staff orientation, or continuing education.	K0147		
K0152	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; and ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities; (iii) File a report and evaluation on each drill; (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. Facilities meet the requirements of paragraphs (1) and (2) of this section for any live-in and relief staff that they utilize.	K0152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G078	A. BUILDING 01 - HOME AGAIN B. WING _____	03/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME AGAIN ICF	2311 ARUBA DRIVE NAMPA, ID 83686

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K0152	Continued From page 13 This Standard is not met as evidenced by: Based on record review it was determined that the facility failed to hold evacuation drills at least quarterly for each shift of personnel. Failure to hold evacuation drills can result in untrained staff and residents that may not react appropriately in an emergency. The facility had a census of eight clients on the day of the survey. Findings include: During record review of the facility's evacuation drill records on March 24, 2011 at 9:37 AM revealed that facility failed to hold first and third shift drills during the first quarter, third quarter and fourth quarter during the previous twelve months. Findings were observed and noted by the facility House Manager and Surveyor.	K0152		

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The facility is a single story, type V (000) wood frame construction with a composite pitched roof and two exits to grade. The facility is fully sprinklered with an NFPA 13R system and has a fire alarm/smoke detection system, as well as battery operated emergency lighting. The facility is currently licensed for 8 beds. The following deficiencies were cited during the life safety code survey between March 24, 2011 and March 28, 2011. The survey was conducted in accordance with applicable fire/life safety requirements set forth in IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF/MR). The annual life safety code survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000	See Plan of Corrections Attached RECEIVED APR 15 2011 FACILITY STANDARDS	
MM311	16.03.11.110.01(a) Structurally Sound The facility must be structurally sound and must be maintained and equipped to assure the safety of residents, employees and the public. This Rule is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that doors are operable and are not locked against means of escape. This deficiency has the potential to prevent people in this room from escaping incase of a fire or other emergency. The facility had a census of eight clients on the day of the survey. Findings include:	MM311		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admn | (X6) DATE: 4/13/11

Bureau of Facility Standards

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MM311	Continued From Page 1 During a tour of the facility on March 24, 2011 at 10:29 AM the House Manager was opening the door to room #7 from the interior when the door knob came off in her hand. The House Manager was unable to open the door without first having to replace the door knob on the opening mechanism. Findings were observed and noted by the facility House Manager and Surveyor.	MM311		
MM345	16.03.11.110.06(f) Portable Fire Extinguishers Portable fire extinguishers must be serviced in accordance with the applicable NFPA Standard 10 (1978 edition), "Portable Fire Extinguishers." This Rule is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that portable fire extinguishers were being inspected on a monthly basis. Inspecting the portable fire extinguishers on a monthly basis helps to ensure that the fire extinguisher is at its intended location and is ready for use in the event it is needed. The facility had a census of eight clients on the day of the survey. Findings include: During a tour of the facility on March 24, 2011 between the hours of 10:00 AM and 10:50 AM observation of the inspection tags affixed to the portable fire extinguishers revealed they had not been initialed and dated since December 15, 2011. Findings were observed and noted by the facility House Manager and Surveyor.	MM345		
MM359	16.03.11.120.01(b) Construction and Additions Prior to commencing work pertaining to construction of new buildings, any additions or	MM359		

Bureau of Facility Standards

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MM359	Continued From Page 2 structural changes to existing facilities, or conversion of existing buildings to be used as a facility, plans and specifications must be submitted to, and approved by, the Department to assure compliance with the applicable construction standards, codes, rules, and regulations. This Rule is not met as evidenced by: Based on observations and staff interview it was determined that the facility failed to contact the Department and receive approval for building alterations prior to commencing work. Findings include: During record review on March 24, 2011 at 9:30 AM the House Manager stated that the facility had added plywood to the walls of room #8 after being asked by the Surveyor if any changes had been made to the facility since the last life safety code survey conducted on June 8, 2010. During a tour of the facility on March 24, 2011 at 10:37 AM observation of room #8 revealed that 15/32 inch plywood had been added to the bottom four feet of each wall in the room. Findings were observed and noted by the facility House Manager and Surveyor. The plywood installed on the walls in room #8 is Class A rated with a flame spread rating of 10, and a smoke development rating of 15.	MM359		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally	MM380		

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MM380	Continued From Page 3 washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that the building and all equipment was in good repair. The facility had a census of eight clients on the day of the survey. Findings include: 1. During a tour of the facility on March 24, 2011 at 10:15 AM observation of room #4 revealed that the window screen was missing. The window screen was found on the ground in the backyard, the screen was torn up and the frame was bent. Findings were observed and noted by the facility House Manager and Surveyor. 2. During a tour of the facility on March 24, 2011 at 10:52 AM observation of the kitchen revealed that the carpet/linoleum transition strip was loose and bent up at one end. Findings were observed and noted by the facility House Manager and Surveyor.	MM380		

Home Again ICF Plan of Corrections for Survey dated March 28,2011

Key:

1. ***Describe what corrective actions will be accomplished for those individuals found to have been affected by the deficient practice.***
2. ***Describe how the facility will identify other individuals having the potential to be affected by the same deficient practice and what corrective actions and what corrective actions will be taken.***
3. ***Describes what measures will be put into place or what systematic change will be made to ensure that the deficient practice does not reoccur. How will the corrective actions be monitored to ensure that the deficient practice will not reoccur, ie. What quality assurance program will be put into place.***
4. ***What is the date that the corrective actions will be completed?***

K130

1. The Scentsy samples have been removed and put on the resident's dresser. The intention of the sensory wax is for use for sensory stimulation.
2. All other resident's rooms have been surveyed to ensure that none of the sensory wax is being placed on or by the heaters.
3. Staff and residents have all been reminded not to put anything on the heaters at any time.
4. 3/28/11.

K0017

1. The doors in bedrooms 1, 6, 5, and 8, have been replaced with solid core doors. The holes in rooms 3 and 4 have been repaired.
2. All doors and walls were inspected and any doors with holes or splits were replaced and holes in walls were repaired.
3. The AQMRP and/or RSM will inspect all walls and doors monthly to identify any holes that need to be repaired or doors to be replaced replaced and will ensure that repairs are completed promptly.
4. All changes will be made by 4/14/11 because the doors had to be ordered and painted.

K0043

1. The handles to the door on sleeping room #7 was replaced on 3/25/11.
2. All door handles were inspected and any loose door knobs were tightened or replaced 3/25.
3. The RSM will survey the home daily and will tighten and/or replace any loose door knobs.
4. All changes will be made by 3/29/11.

K00046

1. The multiple electrical adaptors and extension cord were replaced with power strips. The light switch face place in the office was replaced. The electrical outlet faceplate in room #3 and #4 and under the kitchen dining bar were replaced.
2. All rooms will be inspected to identify any power and light face plates that were missing and broken. Any found were replaced.
3. The RSM will monitor the home daily to ensure no face plates are missing or broken. Any that are missing or broken will be replaced that day. .

4. All changes will be made by 3/29/11.

K0056

1. The storage shelf in the office and exercise room and room #7 were cleared off so that there are no objects below the sprinklers or on that half of the storage shelf.
2. All storage shelves in the closets have been inspected to ensure that there is nothing on the half of the shelf under the sprinklers.
3. All storage shelves in the closets will be inspected monthly by the RSM to ensure that there is nothing on the half of the shelf under the sprinklers.
4. All changes will be made by March 30, 2011.

K0147

1. Staff will review and sign the emergency management plan.
2. Staff will review and sign the emergency management plan.
3. Every other month during staff meetings, the staff will be trained on the emergency management plan.
4. All changes will be made by April 18, 2011

K0152

1. All staff were trained on the importance of documenting fire drills completely including date time and shift.
2. Charge staff were informed of the day and shift for the required fire drill for the next 3 months.
3. The RSM will ensure that fire drills are completed and documented completely on each shift for all residents quarterly.
4. All changes will be made by April 18, 2011.

MM311

1. The handles to the door on sleeping room #7 was replaced on 3/25/11.
2. All door handles were inspected and any loose door knobs were tightened or replaced 3/25.
3. The RSM will survey the home daily and will tighten and/or replace any loose door knobs.
4. All changes will be made by 3/29/11.

MM345

1. The fire extinguisher was inspected and signed.
2. All fire extinguishers will be inspected and signed.
3. The RSM will inspect and sign the fire extinguishers in the home.
4. All Changes will be made by 4/18/11.

MM359

1. (1-3) The RSM will notify the Department before making any structural changes.
2. All changes will be made by 3/30/11.

MM380

1. The screen in room #4 has been replaced. The transition strip will be tacked down.
2. All rooms were inspected to ensure that the screens are on the window.
3. The maintenance list includes an inspection of all windows daily and to report to the RSM any missing or damaged screens. All missing screens are replaced that day. We keep 2 extra screens In the garage to use to replace any broken screens. If more than 2 screens are broken it will take 3 days for new screens to be ordered and installed.
4. All changes will be made by 3/29/201.